A DECADE OF RURAL MENTAL HEALTH CENTRE SAKALAWARA

1976-86

National Institute of Mental
Health and Neuro Sciences (NIMHANS)
BANGALORE-560 029. (INDIA)

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COMMUNITY HEALTH CELL

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CONTENTS

FOREWORD

Care of the mentally ill, particularly in the rural areas, has always been neglected. While field surveys have confirmed the wide prevalence of all forms of mental illnesses all over the country, facilities and resources to care for them, have been limited. It was with the aim of developing and evaluating feasible strategies for extending mental health services that a community mental health unit was started at National Institute of Mental Health and Neuro Sciences. The Rural Mental Health Centre situated at a picturesque 13 acre site near Sakalawara village (Anekal Taluk, Bangalore Rural District) 18 kms. away from Bangalore city was formally inaugurated in December 1976 by Dr. Karan Singh — the then Union Minister of Health and Family Welfare. The centre was started with the co-operation of Mahabodhi Society, which has continued to support all it's endeavours. Ever since then, this centre has been the hub of all community mental health activities at NIMHANS. During the past one decade, the centre has indeed gone a long way in developing a variety of programmes for development of community based mental health care in the country. Starting from the initial feasibility studies during the seventies, the centre has evolved various types of training programmes in basic mental health care for different categories of personnel.

It is most fitting that the completion of a decade of the Rural Mental Health Centre coincides with a 'Review Workshop on Training of Trainers for Mental Health Care' with participants from Jammu and Kashmir in the north to Kerala in the South. This booklet gives a brief account of the development of various programmes and the Current activities of the Rural Mental Health Centre, Sakalawara.

(DR. G. N. NARAYANA REDDY)
DIRECTOR

COMMUNITY MENTAL HEALTH UNIT AND RURAL MENTAL HEALTH CENTRE

— Milestones

1975 October	Appointment of Dr. R.L. Kapur as professor of Community Psychiatry.
1976 August	A multidiciplenary team of 3 Psychiatrists 1 Clinical Psychologist 3 Psychiatric Social Workers and 2 Psychiatric Nurses appointed to constitute the Community Mental Health Unit and team.
1976 December	Inaugaration of Rural Mental Health Centre at Sakalawara by Dr. Karan Singh, Union Minister of Health and Family Welfare.
1976 — 1980	Development of service programme at Sakalawara, Feasibility exercises.
1977 January	'Mental Health Clinic' Opened in K.C. General Hospital Malleswaram to start Community Mental Health Care in Urban Areas involving the General Practitioners.
1977 — onwards	Monthly Seminars in Mental Health for GPs. Various models of GP training programmes evaluated.
1977 — onwards	First orientation course for 28 urban school teachers. Regular interaction with teachers of various urban schools.
1978 — 1979	First Pilot Training Programme for Primary Health Centre (PHC) personnel and its evaluation — Malur PHC.
1978 — 1984	Co-ordination of ICMR Multicentre Collaborative Project on 'Severe Mental Morbidity'. (Bangalore, Baroda, Calcutta and Patiala)
1980 — 1981	Second Pilot Training Programme for PHC personnel and evaluation — Anekal PHC.
1980 — 1982	Short term training programmes in Mental Health Care for GPs of smaller towns and Mental Health Camp Kollegal, Ramanagaram and Mandya.
1981 May	Inauguration of the Outpatient Block at Rural Mental Health Centre by A.K. Abdul Samad, Minister of Health and Family Welfare, Govt. of Karnataka.

1981 August	ICMR Funded Training Programme in 'Extension of Mental Health Services into the Community' for 7 Psychiatrists.
1981 — 1983	Co-ordination of ICMR Multicentre Project on — "Training Programme for non-psychiatrist primary care Doctors" (Bangalore, Hyderabad and Vellore)
1982 April	Regular monthly training programme for PHC personnel from Gulbarga Division started. First batch was inauguarated by Mr. Kagodu Thimmappa, Minister for Public Works, Govt. of Karnataka.
1983 April	Field Level Evaluation of the Training Programme in 4 districts of Gulbarga Division.
1983 July	'MANASIKA AROGYA' — Bimonthly *Newsletter in Kannada* for PHC personnel
1983 September	Mental Health Camps in various PHCs of Bellary District.
1983 December	WHO Funded 'Training of Traminers of PHC personnel for Mental Health Care' for 14 mental health professionals (Psychiatrists, Clinical Psychologists, Psychiatric Social Workers and Psychiatric Nurses) from Andhra Pradesh, Madhya Pradesh, Rajasthan and Uttar Pradesh.
1984 February	First Workshop on National Mental Health programme (NMHP) for state level planners (Health Secretaries, Directors of Health, Medical Education, Senior Psychiatrists)
1984	Pilot exercises and initial training for health care personnel in Bellary District.
1984 June	Programme of Mental Health Promotion in Children of Rural Schools — work initiated in Jegani, High School
1984 July	First batch of 3 days Residential Training for Anganwadi workers in child mental health care.
1984 — onwards	'Mental Health' made part of regular health training programmes of Medical Officers and Senior Health Inspectors, Health & Family Welfare Training Centre at Mandya and Bangalore.
1984 September	Inauguaration of ICMR Centre for Advanced Resarch on Community Mental Health Centre by Mr. B. Shankaranand — Union Minister of Health and Family Welfare.
1984 November	First batch of 'Community Leaders' Sensitization Programme.

1985 April & May	Assessment of Mental Health needs of 'Bhopal Diseaster' affected population — Two batches of Medical Officers working with diseaster affected population trained in mental health aspects of care.
1985 July	Formal Inauguaration of the District Mental Health Programme at Bellary by Dr. H.L. Thimme Gowda, Minister of Health and Family Welfare, Govt. of Karnataka.
1985 August	Second Workshop on NMHP for state level planners from Haryana, Hemachal Pradesh, Maharashtra and Pondicherry. Formal release of the 'Manual of Mental Health for Multipurpose Workers'.
1985 October	Workshop on 'Community Mental Health in India — Formal release of the 'Manual of Mental Health for Medical Officers'
1985 — 1986	Workshop on NMHP in different states for mental health professionals: Andhra Pradesh — (October 1985) Karnataka — (November 1985) Hemachal Pradesh — (November 1985) Maharashtra — (January 1986) Punjab — (January 1986) Rajasthan — (April 1986) Haryana — (April 1986) Tamil Nadu — (April 1986) Kerala — (May 1986) Gujarat — (June 1986).
	Training of PHC personnel in different states with Resource Persons and support from the Unit (Andhra Pradesh, Pondicherry, Hemachal Pradesh, Punjab, Rajasthan, Kerala and Maharashtra)
	'Training of Trainers of PHC personnel for mental health care' (several batches)
1986 February	3rd Workshop on NMHP for state level planners from Kerala, Jammu & Kashmir, Gujarat, Punjab, Tamil Nadu and Goa.
1986 March, April & July	Workshops on NMHP for Psychiatric Social Workers, State level Health administrators and Mass Media personnel and clinical Psychologists
1986 December	Review Workshop on 'Training of Trainees for Mental Health Care' A decade of Rural Mental Health Centre.□

COMMUNITY MENTAL HEALTH UNIT AND RURAL MENTAL HEALTH CENTRE — The First Decade

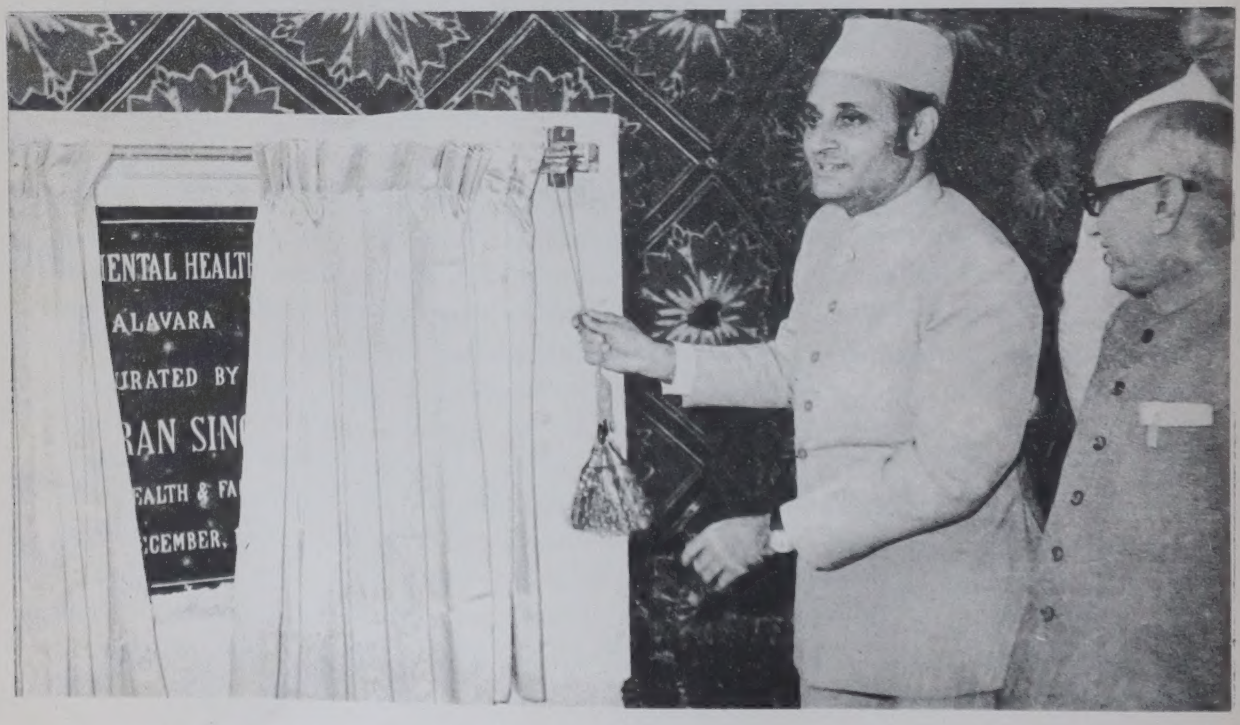
INTRODUCTION

The past three decades have witnessed great strides in the care of the mentally disabled in India. From its predominant mental hospital base, the care of the mentally ill slowly shifted to the general hospital setting. This brought on a new type of care for large number of mentally ill persons mostly from the urban areas. General hospital psychiatric care meant shorter period of the hospitalization with active involvement of the family members in the care of the mentally ill as against the well known long-term, asylum care without any involvement of the family. More and more persons with various less severe psychiatric problems too sought help in the general hospitals. With a steady increase in the number of post-graduate training centres in psychiatry and consequently, the number of trained specialists, private sector for the care of the mentally ill also grew up. But all these facilities came up predominantly in the urban areas, catering only to a small section of the needy population. There was also the additional problem of underutilization of the existing services. It is estimated that, not more than ten percent of those urgently in need of mental health care are receiving the needed help from the presently available facilities, as they are heavily concentrated in the cities.

India is committed to attaining the goal of 'HEALTH FOR ALL BY 2000 A.D.', through the universal provision of comprehensive primary health care services (National Health Policy — Government of India 1982). Promotion of mental health forms one of the components of 'Primary Health Care' (Alma-Ata, WHO 1978). But like in many other developing countries, it is still widely believed that mental disorders are caused by demons, spirits and black magic and that they are cured only by religious, magical and other traditional methods. Health planners, administrators and the medical professionals too are unware of the wide prevalence and suffering caused by mental disorders. The wide ranging misconceptions and ignorance of the population has resulted in poor demand for modern services. In the broader context, even public health services, are still receiving a low priority in terms of resource allocation and mental health in particular has had the least share of public health expenditure. Most of the limited currently available services are institution based and situated in urban areas - either in large custodial mental hospitals or in psychiatric units attached to teaching hospitals.

During the past ten years there has been a growing awareness of the wide prevalence and suffering caused by mental illness in the community. Further major advances have occured

OPENING OF RURAL MENTAL HEALTH CENTRE SAKALAWARA



Inauguration of Rural Mental Health Centre at Sakalawara by Dr. Karan Singh, Union Minister for Health and Family Welfare on December 15, 1976.

in the care of the mentally ill. The shift in care, more recently, was from the hospital to the community and from the specialist to the generalist. To bridge the wide gap between 'need' and 'available services' in the field of mental health, feasible alternative approaches to extend care had to be developed and evaluated. The Department of Psychiatry, at the National Institute of Mental Health and Neurosciences, addressed itself to the problem of organisation of mental health services in the community, during the early seventies. The outcome of this desire to develop meaningful strategies within the constraints of limited trained personnel, facilities and financial supports has been the starting of a specially designated 'Community Mental Health Unit', within the department of Psychiatry, the first of its kind in the country. This paper describes the genesis, growth and activities of the Community Mental Health unit at NIMHANS from 1975.

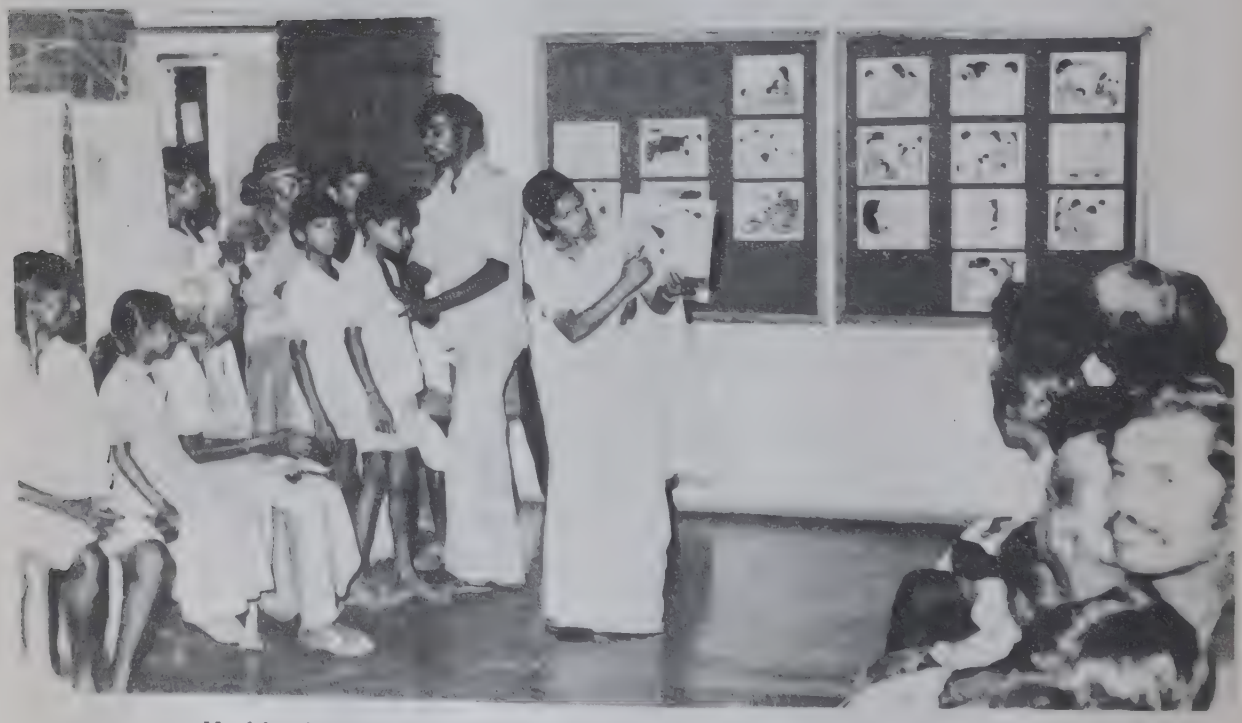
GENESIS OF THE COMMUNITY MENTAL HEALTH UNIT

Several Psychiatric epidemiological investigations carried out across the country, threw light on the uniform and wide prevalence of all types of mental disorders, in both urban and rural populations. These studies indicated that the number of people suffering from serious neuropsychiatric conditions needing urgent attention, in the whole country were in the range of several millions. Increasing number of trained personnel, improved facilities and thus better care for those who have access to the available services, showed that early recognition, management with modern psychopharmacological agents and properly organised rehabilitation programme could control symptoms as well as prevent secondary handicap for most mental disorders. Unfortunately, this mental health 'knowhow' did not reach most of those who could greatly benefit from them due to the centralised and professionalised nature of the existing services as well as the paucity of resources, (like trained personnel and facilities like hospital beds, essential drugs, etc.) to adequately cover the needy population.

For a projected 6½ to 7 million mentally ill and an equal number of epileptics in 1975, there were only about a 1,000 mental health professionals and 20,000 hospital beds. Therefore it was unrealistic to hope that adequate mental health services for the country could be organised through trained professionals alone. There was a need to develop cost-effective alternative approaches of mental health care. The growing consensus of opinion amongst experts in the field — national and international — was, 'decentralisation and integration of mental health services with the general health services by training the existing general health care personnel to provide basic mental health care'. An expert committee of the WHO on organisation of mental health services in developing countries which met in 1974 (WHO 1975) urged member states to recognise mental disorders as a problem of high priority for the individual, for the community and for national development and made several important recommendations. The committee recommended that: **"Countries should, in the first instance carry out one or more pilot programmes to test the practicability of including basic mental health care in an already established programme of health care in a defined rural or urban population"**. It further recommended that **"training programmes, including a simple manual for the training of health workers should be devised and evaluated"**. It was with the aim of developing,

SERVICE & TRAINING ACTIVITIES

Treating the mentally ill in the home setting.



Health education in the OPD at Rural Mental Health Centre, Sakalawara.

evaluating and carrying out suitable training programmes in basic mental health care for different categories of personnel, that the community mental health unit was started at NIMHANS in 1975.

The Community Mental Health Unit started functioning as a part of the Department of Psychiatry from October 1975, with the appointment of Dr. R. L. Kapur as the Professor of Community Psychiatry. After the initial few months of planning, the rest of the multi-disciplinary team—3 psychiatrists, 1 clinical psychologist, 3 psychiatric social workers and 2 psychiatric nurses joined the unit in August 1976. The Unit decided to initially concentrate its activities in the following three major areas: (1) Mental Health care for rural areas (2) Mental Health care in urban areas and (3) Mental Health care in schools. The work completed in the three above mentioned areas are as follows:

MENTAL HEALTH CARE FOR RURAL AREAS

The Unit decided to develop suitable short-term training programmes in 'basic mental health care' for the Medical Officers and Health workers of Primary Health Centres (PHC) so that, after the training, the PHC personnel could provide basic mental health care in their respective catchment areas. The plan was to establish a 'Rural Mental Health Training Centre'. By 'basic mental health care', it was meant, detection and management of all psychotics and epileptics which between themselves have a prevalence rate of 0.5 to 2%. These two conditions were chosen for attention since (a) they are easily recognisable (b) cause maximal distress and social dysfunctioning and (c) are amenable to simple therapeutic strategies.

RURAL MENTAL HEALTH CENTRE AT SAKALAWARA

As an initial step, a decision had to be taken regarding the venue of the training programmes for the PHC personnel. NIMHANS and the mental hospital atmosphere as the primary venue for the training was considered and found not appropriate as the urban and institutional atmosphere of NIMHANS would be unsuitble for a short-term, practical, intensive, in-service training for primary care personnel, who, by and large live and work in rural areas. While the primary health centre set up was considered ideal for training purposes, it was realised that such a set up should have the potential to ultimately become a permanent centre for regular inservice training of batches of primary health care personnel. Hence, it was decided to set up a separate rural mental health training centre (physicaily away from NIMHANS), and create a setting similar to that of a Primary Health Centre (PHC). It was thought that the rural atmosphere as well as the setting similar to a PHC would be ideally suited and inspiring for any intensive short-term training in basic mental health care.

The rural mental health training centre was set up in the village 'Sakalawara', about 15 kms. away from NIMHANS. There was already a small primary health care facility in this village, run by a voluntary organisation of Bangalore called the 'Arogya Foundation of the Mahabodhi Society'. They had acquird a 13 acre plot of land near the village and had developed it into a small campus - the Bodhigrama - with a main building for offering the

primary care facility and few living quarters for paramedical staff. Their constant efforts had resulted in horticultural development of the land and the Mahabodhi Society had long-term plans of development work in Sakalawara and nearby villages. NIMHANS had experience of previously working with the Mahabodhi Society from the mid sixties at Sakalawara. One of the first psychiatric epidemiological surveys in the country was completed in Sakalawara village (Gopinath, 1969) and weekly mental health clinics were conducted for a certain period of time in the campus. Thus the Sakalawara campus of the Arogya Foundation (and Mahabodhi Society) appeared to be an ideal site for setting up the rural mental health training centre. It was decided that NIMHANS the would collaborate with voluntary agency 'Arogya Foundation' in setting up the rural mental health training centre. While the required buildings and other training facilities could come up in the land owned by 'Arogya Foundation', the technical and professional inputs could be offered by NIMHANS, through the community psychiatry unit. It was, then, hoped that this collaboration could set an example of active co-operation between governmental and voluntary sectors in the implementation of innovative programmes.

The plan was to build an out patient block to provide the primary health care needs of the near by villages along with out-patient care for neuropsychiatric patients and limited in-patient facilities. In addition, residential facilities for the staff — at least one medical officer, two nurses and other supporting staff — facilities for the stay of regular batches of about 25 to 30 trainees (doctors, health workers etc.) and kitchen and mess facilities for the trainees were planned. The existing old building at the campus was to be renovated to house the offices, lecture halls, rooms for group discussions, records, stores, etc. The work on these were taken up with grants sanctioned by the Karnataka Government. The rural mental health centre was formally inaugurated in December 1976 by the then Health Minister of Government of India, Dr. Karan Singh.

Sakalawara is situated in Anekal Taluk of Bangalore Rural District, about 20 kms. to the South East of Bangalore city and 3 kms. off the Bangalore Bannerghatta – Anekal road. The nearest health centre is the Anekal PHC and is more than 20 kms. away. The nearest Primary Health Unit (PHU) is about 5 kms. from Sakalawara. Unlike other neighbouring taluks Anekal taluk was least industrialized.

SERVICE PROGRAMME AT SAKALAWARA AND THE FEASIBILITY STUDY

The first task taken up towards the fulfilment of the final objective of integrating mental health with primary health care was the starting of a service programme at Sakalawara. A tri-weekly and later daily primary health care clinic was organised at the centre. In addition, an active field programme of identification and management of epileptics and psychotics from the villages around Sakalawara was taken up. This was taken up primarily to gain experience regarding (a) the manner in which epilepsy and psychosis presented in rural areas (b) the perception and attitudes of the community towards these conditions (c) the response of the patients as well as their family to the treatment within the family setting (d) response of the community to mental health education. It was hoped that this experience would be helpful in developing training strategies which would be appropriate to the context in which the primary health centre personnel function.

The service programmes and the feasibility studies were carried out by a team of one psychiatrist, one psychiatric social worker and one psychiatric nurse. The team visited villages around Sakalawara, collecting basic socio-demographic data as well as information about persons with epilepsy and psychoses. The patients were examined at their homes and the treatment started. Following this, for follow-up they were asked to report at the Sakalawara centre. Since the ultimate aim was to train the PHC personnel to deliver mental health care as part of general health care, the team also provided primary care services during village visits, in addition to that at the centre. In all these villages, the problems of poverty, malnutrition, infectious diseases and other public health requirements i.e. the greater need for better primary health care was striking. During the teams' efforts to identify persons with epilepsy and psychoses in the villages, it was realized that these conditions could not be isolated as special problems from the existing need for better primary health care. Responses like 'give something for my son's diarrhoea now, I shall think about what you have to offer for my mother's mental illness later' indicated that people wanted remedy for their acute physical illnesses first before listening to what could be done for the mentally ill and epileptics. It was evident that mental health care cannot be delivered in isolation from primary health care, in rural areas.

Identifying the severely mentally ill and the persons with epilepsy posed no problems. They were identified by a simple method of asking a few questions to any 3 to 5 per cent of the adult population of the village. Majority of the people thus questioned showed no hesitation in reporting mental illness or fits in others and this information was obtained quite easily. This simple questionnaire, which takes only few minutes for administration, has been validated against other accepted methods of psychiatric case finding and has been shown to be effective in identifying the persons with psychoses and epilepsy with almost 100% efficiency (Isaac & Kapur 1980). Key informants like the village head, the temple priest, the school teacher and formal and informal leaders were involved as much as possible in the identification, management and simple mental health education of the villagers.

While working with the villagers around Sakalawara, it was observed that the best way of giving health education was to demonstrate a recovered patient. The team facilitated the recovered patient and his family members talking about their illness and recovery through treatment to large number of villagers at informal meetings. After the patient and his family had spoken, the members of the team talked to the group concentrating on the following points: (i) mental illness is not due to evil spirits as it was shown to have been relieved through medications, in the demonstrated case (ii) for a long term relief from symptoms and cure, regular medication is necessary (iii) it does not help to beat the psychiatric patient, kindness is therapeutic and (iv) suitable work for the patient is an important part of therapy.

During this initial phase of organising the service programme and the feasibility study (1977-80), 122 villages with population of 76,000 within a radius of about 12 kms. from Sakalawara were covered. This experience has been reported in detail elsewhere. (Chandrashekar *et al*, 1981, Isaac *et al* 1981, Parthasarathy *et al* 1981). This phase of work highlighted several issues (Tables 1 to 6)

TABLE — 1

Total No. of villages covered — 120
Population — 75,649 (in 1980)

Year	Coverage of villages (Cumulative)	Coverage of population	New patients detected and managed Schiz.	Ac. Psy.	M.D.P.	Epilepsy	Total
1977	50	39,000	14	4	10	85	113
1978	58	45,000	2	8	3	20	33
1979	100	65,000	20	8	8	98	134
1980 (9 m. only)	120	75,600	15	10	6	65	96
TOTAL			51	30	268		376

TABLE — 2

DURATION OF ILLNESS AT DETECTION — SCHIZOPHRENIA

Duration of illness	Number	Percentage
1 — Less than 2 years	2	4
2 — 5 years	14	27
6 — 10 years	17	33
11 — 15 years	7	14
16 years and above	11	22
TOTAL	51	100

96% were ill for 2 years and above.

TABLE — 3

DURATION OF ILLNESS AT DETECTION — EPILEPSY

Duration	Number	Percentage
Less than 6 months	37	14
6 — less than 12 months	17	6
1 — less than 3 years	64	24
3 — 5 years	55	21
6 — 10 years	52	19
11 — 20 years	27	10
20 years and above	16	6
TOTAL	268	100

TABLE — 4

PREVIOUS CONSULTATION PATTERN — SCHIZOPHRENIA AND EPILEPSY

Agency consulted	Schizophrenia No.	%	Epilepsy No.	%
Traditional healers only	23	45	102	37
Traditional healers and doctors	3	6	94	34
Traditional healers and NIMHANS	25	49	49	18
Nil	—	—	29	11
TOTAL	51	100	274	100

TABLE — 5

SEVERITY OF DISABILITY AT DETECTION — SCHIZOPHRENIA

Severe : Patient doing no useful work/wandering/nuisance, has to be looked after.
Moderate : Can take care of himself but cannot do any useful work.
Mild : Can be forced to do little work.
Minimal : Patient is almost normal.

Disability	Number	Percentage
Severage	24	47
Moderate	20	39
Mild	7	14
TOTAL	51	100

TABLE — 6

RESPONSE TO TREATMENT — SCHIZOPHRENIA (31 PATIENTS)

Disability	At detection		After treatment	
	No.	%	No.	%
Severe	17	55	0	0
Moderate	12	39	2	6
Mild	2	6	14	47
Minimal	0	0	14	47
TOTAL	31	100	30	100

One patient died during the period of feasibility study.

- ★ Severely mentally ill and epileptics are present in the villages.
- ★ Many of them are ill for several years with significant disability in personal, social and vocational functioning.
- ★ Most of them suffer from treatable conditions.
- ★ Almost all of them consult traditional healers.
- ★ Although about 50% of the patients had at least once consulted an allopathic doctor, most of them were not on any treatment at the time of detection and had moderate to severe disability.
- ★ Majority of the identified persons with psychoses and epilepsy could be cared for in their home settings.
- ★ Only 4 per cent of the identified patients needed to be hospitalised.
- ★ Severe and chronic psychoses responded to regular treatment.
- ★ While detection of epilepsy and psychoses was rather easy, convincing the family members to accept long term medication and regular follow-up needed constant education.
- ★ Cost of treatment could be curtailed by using limited range of drugs.
- ★ Improved patients form examples to motivate other patients in the same village and nearby villages to take regular help.

FIRST PILOT TRAINING PROGRAMME FOR PHC PERSONNEL — MALUR PHC (1978–79)

The experience gained during the 1st phase of work at Sakalawara, helped in developing a short 2 day course for PHC doctors and Multi Purpose Workers (MPWs) with simple tools for evaluation of the training. A pilot training course was organized at the PHC at Malur, 48 kms. away from Bangalore. The doctors were trained in the clinical features and management of psychosis and epilepsy and were administered a questionnaire on causes, clinical features and management of various types of psychosis and epilepsy, both before and after the training. The multipurpose health workers were trained in regard to the nature, causes and treatment of severe mental illnesses and epilepsy, in Kannada. They were assessed both before and after the training by a questionnaire. Eight Governmental doctors and fifty-nine MPWs took part in the training. The pertaining assessment showed that the orientation towards mental health of both, the doctors as well as health workers was unsatisfactory. They had poor knowledge regarding mental illnesses. The two days training improved their orientation and knowledge of mental illnesses as was shown in the post training assessment (Kalyanasundaram *et al* 1980 Kapur *et al* 1980). This course for the PHC personnel was followed up for the next 6 months by monthly visits to the PHC and meeting the trained health workers and doctors. In the follow-up period, it was observed that, while several cases of psychosis and epilepsy were identified, their numbers were lower than expected. The PHC team faced several difficulties in regularly following up these patients. The training mainly served as an orientation course for the PHC personnel. Additional inputs by way of further training were required if the health care personnel were to take up mental health work.

SECOND PILOT TRAINING PROGRAMME FOR PHC PERSONNEL — ANEKAL PHC (1980–81)

The training programme and its follow up at Malur PHC helped in the development of 2 separate and short manuals of instructions in basic mental health care for PHC doctors and multipurpose workers and improved tools for evaluation of training. These manuals were tried in Anekal PHC (Isaac *et al* 1982). Two doctors of the PHC and eleven MPWs who worked closest to the PHC were trained over 15 weekly sessions of 2 hours each (13 of which were for training purposes and the remaining two for pre and post training assessments. The teaching sessions, were brief lectures based on the manual, followed by informal discussion. The MPWs were taught in Kannada. All sessions were accompanied by either live case presentation or presentation of clinical stories. The training was evaluated by pre and post training assessments, which showed that the increase in knowledge was satisfactory. The training of the personnel in this PHC resulted in the starting of a mental health clinic at Anekal one afternoon of the week, initially fortnightly and later weekly, which is continuing to function now. The clinic is conducted jointly by the PHC team and the community psychiatry unit staff.

EDUCATIONAL OBJECTIVES FOR MENTAL HEALTH TRAINING OF PHC PERSONNEL

The experience from the initial feasibility exercise and setting up of the service programmes

ICMR Training in Community Mental Health, August 10-22, 1981. Trainees with the faculty pose with Mr. A.K.Abdul Samad, Minister for Health and Family Welfare, Govt. of Karnataka.

at Sakalawara and the two pilot training programmes for PHC doctors and multipurpose workers at Malur and Anekal PHCs which facilitated both formal and informal interaction with health personnel of the PHC, helped the unit to crystallise the educational objectives for mental health training of PHC personnel. These experiences also helped in meaningfully rewriting the Manuals of instructions in basic mental health care for doctors and health workers.

The educational objectives with respect to MULTIPURPOSE HEALTH WORKERS are as follows: They should be able to:

a) Recognise early all the persons with psychoses, mental retardation and epilepsy in the community.

b) Refer these patients to the PHC doctor.

c) Follow up these patients in the community.

d) Provide first-aid in psychiatric emergencies, and

e) Educate the family members and the community regarding mental disorders.

The educational objectives with respect to the PRIMARY HEALTH CENTRE DOCTORS are as follows: They should be able to:

a) Diagnose different types of psychoses, neuroses, mental retardation and epilepsy.

b) Initiate the necessary pharmacological treatment.

c) Offer guidance and counselling to families with mentally ill and mentally retarded persons.

d) Supervise and guide the multipurpose workers in the follow-up of all identified cases.

e) Refer suitable cases for specialist opinion and help.

With the above mentioned objectives the pyramid of mental health delivery would be as in Figure 1.

FIGURE - 1

	Function
Mental Hospital, Medical College Unit, District Hospital Specialist	– Long term care, diagnosis and management of difficult cases: Training & Monitoring.
↑ ↓	
P.H.C. Doctors	– Diagnosis, Management, Supervision of MPWs, Referral
↑ ↓	
Multipurpose workers	– Detection, Referral, Follow-up, Community Education, First-aid.
↑ ↓	
Mental illness, epilepsy and mental retardation in community.	

The crystallisation of the definitive educational objectives for the health personnel and the revision of the manuals helped the unit to develop a regular 2 weeks training programme for these personnel.

MONTHLY SHORT TERM TRAINING PROGRAMME FOR PHC PERSONNEL AT SAKALAWARA (1982 ONWARDS)

The unit was ready to launch its regular training programmes from April 1982, when the construction of the training centre with residential facilities was completed. The Arogya Foundation and NIMHANS had mutually agreed for the take over of the Sakalawara campus by NIMHANS in 1981.

The new out-patient block was formally declared open by the then Health Minister of Karnataka Mr. A. K. Abdul Samad in May 1981, and the regular training programmes were started in April 1982. With the active cooperation of the Government of Karnaraka, through the Directorate of Health Services, batches of PHC medical officers and multi purpose

health workers are regularly trained in basic mental health care at the Sakalawara centre since then. During the first 20 months i.e. from April 1982 to December 1983, these personnel were deputed from various PHCs in Gulbarga Division i.e. from the four northern Karnataka districts of Bellary, Gulbarga, Raichur and Bidar. Currently, trainees are deputed from Mysore Division in addition to Gulbarga Division.

The training period is 12 working days (2 weeks) and it is residential. In order to achieve the educational objectives (as mentioned already) for MPWs and doctors and to provide them with mental health knowledge and skills, the training programme includes clinical and field work as important components. This is in addition to lectures and group discussions. The health workers, after the initial classes at Sakalawara, are given the exercise of identifying the persons with psychoses, mental retardation and epilepsy in the villages around the rural centre and carry out mental health education to the general public. Clinical demonstrations of different types of psychoses, mental retardation and epilepsy are held at Sakalawara out-patient clinic as well as at the NIMHANS. After initial sessions of demonstrations the trainees are asked to interview and assess persons with psychoses and epilepsy. The trainees are taken to the PHC Mental Health Clinics at Anekal and Marsur to interview patients on regular follow up at these clinics. They also interview patients and their family members in their home settings in the villages. An important feature of this two week training programmes is that several sessions are held jointly for doctors and health workers to facilitate future team work. The curriculum for the health workers consists of: mental health in primary health care, brain and behaviour, causes, nature and treatment of mental illness, epilepsy and mental retardation, mental health education and tasks of health workers.

The areas covered for the doctors are: Current status of mental health care in India and integration of mental health in primary health care, brain and behaviour, common symptoms of mental illness, history taking and examination, clinical features and practical management of psychoses, epilepsy, neuroses, mental retardation and other common childhood problems, drugs in psychiatry, counselling, rehabilitation and mental health education.

The training is evaluated by pre and post training assessments and this gives an indication of the knowledge gained by the trainees. While it is acceptable that the ultimate criteria of evaluation will have to be the ability of the MPW to recognise, refer and follow-up mentally ill persons in their areas of work and the ability of the PHC doctor to manage these cases thus bringing down the overall neuropsychiatric morbidity, this can be achieved only by long-term planning and evaluation. The immediate evaluation of the knowledge gained helps in the monitoring of the 2 weeks training programme. While the basic structure of the training has remained more or less the same, constant changes in the finer contents of the curriculum, the method of training, time spent for field work, health education, etc., were incorporated into the training based on the feed back obtained from the trainees. These feedbacks were got both informally and formally through their pre and post training assessments. Based on the feedback from the trainees and their evaluation, it was decided in January 1984 to restructure and shorten the training period for health workers to six

OPENING OF THE NEW OPD BLOCK AT SAKALAWARA

Mr. A.K. Abdul Samad, Minister for Health and Family Welfare, Govt. of Karnataka, inaugurating the Outpatient Block of Rural Mental Health Centre, Sakalawara, on May 6, 1981.

Dr. Helmut Sell, Mental Health Advisor, SEARO, WHO speaks on the occasion.

working days. It was also noticed that having medical officers and health workers together at the training centre and having few joint sessions with the aim of facilitating team work later did not seem to have any special advantage. Hence it was decided that as a routine, the health workers training will be carried out during the first week of every month and the doctors training during the second and third weeks. Till December 1986, 215 Medical Officers and 376 Health Workers from various PHCs of Gulbarga and Mysore divisions have been trained in basic Mental Health Care.

The regular monthly training programmes for health personnel and their evaluation facilitated frequent reviews and revisions of the 'Manual of Instructions'. After several revisions the rewritten drafts of the 'Manual of Mental Health for Multipurpose Workers' and 'Manual of Mental Health for Medical Officers' were finalised and printed for wider use and larger circulation in 1985. (Isaac *et al*, Srinivasa Murthy *et al*, Chandrashekar *et al*).

EVALUATION OF THE MONTHLY 2 WEEKS TRAINING PROGRAMME

An informal field level evaluation of the outcome of the 2 weeks training programme was carried out in April 1983, i.e. one year after the regular training programmes were initiated in Gulbarga division and in November 1985 in Mysore Division. Fifteen PHCs (in each division) from where personnel were trained in mental health care, were personally visited and the concerned medical officers and health workers interviewed regarding the mental health care provided by them following training. This evaluation greatly enhanced the Unit's awareness regarding the various operational problems. (Narayana Reddy *et al* 1986)

None of the personnel felt that the provision of mental health care was an additional burden. They reported that they could carry out these tasks along with the ongoing work. Some of them pointed out that carrying out mental health work along with their multi-purpose health care activities, would help in bringing down the stigma and misconceptions regarding mental illnesses, as it is presently happening with the leprosy programme. Lack of adequate support to the trained personnel by way of sufficient drug stocks of minimum drugs and health education materials like posters was identified as a major impediment for meaningful implementation of the programme. Absence of an inbuilt system of recording and reporting of the work done, supervision of the personnel at various levels, and non availability of a psychiatrist at the district level were issues that limited the success of the programme.

'MANASIKA AROGYA' - BI-MONTHLY NEWSLETTER FOR PHC PERSONNEL (SINCE JULY 1983)

An outcome of the evaluation was the starting of bi-monthly mental health newsletter 'MANASIKA AROGYA' in Kannada since July 1983. This newsletter regularly contains certain mental health educational items in addition to news of delivery of mental health service activities and responses from trained personnel. It is sent to all the PHCs in the Gulbarga & Mysore division, all the trained personnel and administrative officers of all the districts and divisions in the health department and directorate (Karnataka).

INAUGURATION OF TRAINING PROGRAMME FOR PHC PERSONNEL

Inauguration of Training Programme for PHC doctors and Health workers - April 22, 1982. Dr. G.N. Narayana Reddy welcomes the dignitaries. Mr. Kagodu Thimmappa and Mr. Abdul Samad, Ministers for Public Works and Health respectively, Govt. of Karnataka and others.

A batch of medical officers from Anekal PHC during a training session at Rural Mental Health Centre.

CONSEQUENCES OF THE EVALUATION - MENTAL HEALTH CAMPS IN BELLARY DISTRICT: SEPTEMBER 1983

As a consequence of this evaluation visit and in response to the observation that although several patients were identified by the health workers, treatment schedules could not be started for most of them, mental health camps were organised in 3 PHCs of one of the districts (Bellary) of Gulbarga division in September 1983. These camps were conducted by the trained PHC personnel along with 2 members of the community mental health unit. Large number of persons with epilepsy and psychoses were started on treatment during these camps. They are presently under regular follow up at the respective PHCs. An outcome of the evaluation visit and the mental health camps has been the sensitization of the supervisory officers at the district level and divisional level, namely, Asst. District Health Officers, District Health Officers.

THE DISTRICT MENTAL HEALTH PROGRAMME - 1984

By early 1984, the Unit had gained sufficient experience in community based mental health services and a conviction in the feasibility of involving general health care staff for mental health care. Starting from the setting up of service programmes in Sakalawara from 1976, through the pilot training programmes, definition of educational objectives, construction and revision of manual for health personnel, development of regular two weeks training at Sakalawara and its evaluation in 1983, the Unit was convinced about the necessity as well as the possibility of inclusion of mental health as one of the elements of primary health care in the Indian setting. During the same period another major effort elsewhere in the country — "Strategies For Extending Mental Health Care" project, a WHO multicentre collaborative study with a collaborating centre at Chandigarh — had practically demonstrated that primary health care workers can deliver mental health care at the community level. Few other experiments from different centres in the country — Vellore, Lucknow, Hyderabad too had added to the growing evidence, for community based mental health care by general health staff. These efforts had contributed to the drafting of a national mental health action programme which culminated in the acceptance and adoption of the programme by the Central Council of Health and Family Welfare.

These positive developments made the unit aware of its increasing relevance and continuing responsibilities to consolidate the present gains and the urgent need for operationalising and applying the existing knowhow to larger areas and target populations. The already proven methods of training, manuals, curricula, aids of various nature developed for the training and methods of evaluation had to be applied in a wider setting. Manuals, health education materials which can be used by health care personnel, simple records for registering and follow-up of cases by MPWs and Medical Officers, sufficient supply of limited range of essential drugs, etc., had to be made freely available at the PHC setting. A system of identification, recording, referral, follow-up and supervision at various levels, namely, the levels of the MPW, health supervisors, PHC medical officers, District health officer and the state level directorate of health services had to be developed. The district level psychiatric facilities of referral and consultation by the PHC teams had to be developed. So there was an urgent need for operationalising existing know-how to larger areas and target population.

It was noted that a district and not a PHC was the planning and implementation unit for most other health care programmes. Several of the advantages of planning at a district level applied equally to mental health care. Some of these are:-

1. The district is an independent administrative unit with district commissioner as the head.
2. DHO, has powers of planning activities in the district.
3. Monitoring of programmes occur at the district level.
4. Inter-sectoral coordination is possible at the district level.
5. Mobilisation of additional resources is possible.
6. All existing staff can be best utilised by involving the total district for care programme.

Above all, it was noted that the plan of action outlined in the NMHP aimed at "the full operationalization of a mental health care programme in at least one district of every state in a period of five years". It was in the light of all these factors that a district mental health programme was conceived and developed by the unit. The programme envisaged complete coverage of a whole district (pop. 1.5 million) by training all the existing general health care staff within a reasonably short period of time and in a staggered fashion. This movement from a PHC to the district level meant a larger commitment on the part of the state health directorate. One of the districts in Gulbarga division namely Bellary was selected for the District mental health programme.

Bellary District, situated in the mid-eastern portion of Karnataka State, has 8 taluks and a population of 14,87,062 (1981 census) which constitutes a little over 4 percent of the total population of the State. There are 17 PHCs, 7 General Hospitals, 33 PHUs, 4 Urban Family Welfare Centres and 4 National Leprosy Control Centres in the district, in addition to the Medical College and Hospital at Bellary. There are about 100 Medical Officers and 500 Health Workers (including supervisors) manning the various health care institutions.

The General Aim of the District Mental Health Programme (DMHP) is to extend mental health services to the severely mentally ill persons in the district through the existing health and welfare personnel. The more specific objectives of the Programme are:-

1) To develop a decentralized training programme in mental health for all categories of health personnel, appropriate to their levels of functioning with least disruption to the ongoing general health care activities.
2) To provide a minimum range of essential mental health care drugs for treatment of severely mentally ill persons at all peripheral health care institutions.
3) To develop a system of simple recording and reporting of care by health care personnel.
4) To assess and monitor the effect of the service programme in terms of treatment utilization and outcome with treatment, and
5) To study the cost-effectiveness of the programme.

Towards achieving the above objectives the district programme has been planned as a unique collaborative project of NIMHANS (through the community mental health unit), the directorate of health and family welfare services (through the district health officer at Bellary) and the District administration (through the Deputy Commissioner). The programme was formally inaugurated by Dr. H. L. Thimme Gowda, the then health minister of Karnataka in July 1985. The unit has developed a decentralized training strategy to be carried out in a phased manner, and a system of simple recording, reporting and regular monitoring. All the health personnel in the district have received two phases of training and the recording, reporting, monitoring system is currently in operation. The Directorate of Health and Family Welfare Services deputed an Assistant Surgeon for a specially designed 6 weeks training at NIMHANS, who after the training, joined the DMHP as its Programme Officer at Bellary. He is assisted by 2 research officers appointed by NIMHANS. This District team assisted by resource persons from NIMHANS monitors the programme by monthly visits to the peripheral institutions. The district administration supported the regular supply of drugs and printing of records required for the programme. A 'District Mental Health Committee' constituted and chaired by the Deputy Commissioner reviews the programme periodically. To improve the utilization of services by the community at all institutions in the district, several activities have been initiated. These include incorporation of mental health in all health education activities in the district, constant interaction with personnel of other departments like Social Welfare and Education and Voluntary Organizations. Presently, there are about 3500 neuropsychiatric cases registered and receiving regular care in various peripheral health care institutions of the district (*District Mental Health Programme at Bellary* First Annual Report - 1986).

It is hoped that with the above activities carried out in a collaborative fashion by the 3 agencies involved in the project as well as other governmental and non-governmental resources available in the district, will truly integrate mental health with the existing health care and welfare infrastructure of the district and provide mental health care to large number of those urgently requiring it. It is also hoped that the district approach to extent mental health services will ultimately emerge as a feasible model for the implementation of NMHP all over the country.

COMMUNITY PARTICIPATION IN MENTAL HEALTH THROUGH VILLAGE LEADERS.

In continuation with other innovative activities the NIMHANS Rural Mental Health Centre, Sakalawara planned and organized Orientation programmes in mental health exclusively for batches of village leaders. The first batch was oriented in November 1984.

During the field visits the village leaders were identified by psychiatric social worker applying simple sociometric techniques. All these identified leaders were individually met and were explained about the programme. 30 leaders from 10 villages were oriented in 6 batches. The orientation programme consisted of familiarising the agency's service and personnel and then exposure to scientific information on mental health,this was done in 4 sessions. Along with discussions audiovisual aids were also utilised and the participants were provided

WHO WORKSHOP FOR "TRAINERS OF TRAINEES" IN BASIC MENTAL HEALTH CARE

'Training of Trainers of PHC Personnel' - December 1983. Dr. G.G. Prabhu, Professor of Clinical Psychology leads a discussion session.

Dr. Mouthurangamme, Senior Psychiatrist, Pondicherry, a participant of 'Training of Trainers' - January 1985 batch, gives the 'Participant's response' during the Feedback session.

with materials for day to day reference. The last part of the programme was concluded with discussion on their roles and participation in mental health problems.

Observations showed that there was difficulty in selection of the village leader - Non acceptance on their part resulted mainly due to lack of familiarity of such educative programmes. Paucity of time and village politics prevented them from attending the programme. All the leaders who attended however spent their full day, participating with keen interest and curiosity. Later they undertook the following activities which consisted of sharing their knowledge with other villagers, identification of the needy patient and referring them to the centre, discussion with family members, organization of health education meetings and they continued to contact agencies for consultation.

THE NATIONAL MENTAL HEALTH PROGRAMME AND THE COMMUNITY MENTAL HEALTH UNIT - TRAINING OF TRAINERS

During the years 1981-82 at the national level, experts in the field of mental health formulated a National Mental Health Programme for India (NMHP). This programme ensures the availability and accessibility of basic mental health care for all in the foreseeable future all over the country. This is planned to be achieved by integrating mental health care services with the existing general health services. The objectives of the programme are:-

i) To ensure availability and accessibility of minimum mental health care for all, in the foreseeable future, particularly to the most vulnerable and under-privileged sections of population.

ii) To encourage application of mental health knowledge in general health care and in social development.

iii) To promote community participation in the mental health services development and to stimulate efforts towards self help in the community.

The Central Council of Health and Family Welfare — the highest policy making body in the field of health in our country — in its meeting held on 18-20, August 1982, recommended that: i) Mental health must form an integral part of the total health programme and as such should be included in all National policies and programmes in the field of health education and social welfare; ii) realising the importance of mental health in the course curriculae for various levels of health professions; suitable action should be taken in consultation with the appropriate authorities to strengthen the mental health education components.

The unit recognized the need to examine the feasibility of approaches developed by it in different parts of the country, in settings with limited facilities and in different health infrastructure. Personnel and other resources for the implementation of NMHP all over the country had to be developed too. Therefore it was necessary to train mental health professionals in the field of community mental health, especially in the new tasks of integrating mental health with primary health care services and training the existing PHC personnel in basic mental health care.

The World Health Organization had recommended in 1975 that **specialized mental health workers should devote only a part of their working hours to the clinical care of patients, the greater part of their time should be spent in training and supervision of non-specialized health workers, who will provide basic mental health care in the community.** It also recommended that **"the training of mental health professionals should include instructions and supervised experience in this new task of training and supporting non-specialized health workers"**. In view of this, a programme primarily meant for mental health professionals from India and other similar developing countries on delivery of mental helth services was developed. The programme initially termed 'Training in extension of mental health services into the community', has metamorphosised into the present 'Training for Trainers of PHC personnel in Mental Health Care'.

The **first** training programme of six weeks, assisted by ICMR was organized from 18th July 1981 to 28th August 1981 at Bangalore, Chandigarh and New Delhi. Seven Psychiatrists from different parts of the country (Andhra Pradesh, Rajasthan, Meghalaya, Harayana, Assam, Gujarat and Uttar Pradesh) were exposed to the various approaches for delivery of mental health services. They were provided with necessary skills for initiating programmes of extending mental health care in the community. Following the training, few of the participants initiated valuable projects in their respective centres which have now become ongoing programmes.

The **second** programme, assisted by WHO, was held in Bangalore in December 1983. Unlike the first, teams consisting of psychiatrists, Psychiatric Social Workers, Clinical Psychologists and Psychiatric Nurses from 4 centres namely, Lucknow (UP), Gwalior (Madhya Pradesh), Hyderabad (AP) and Jaipur (Rajasthan) numbering 14, participated in this programme. They were offered an intensive 3 weeks supervised experience in training and supporting non-specialized health care personnel for mental health work.

Based on the experience from the first two programmes, a standardized 4 weeks training programme is developed. This 4 weeks programme is for mental health professionals aiming to initiate programmes of integrating mental health with primary health care. The programme adopts the methodology of 'adult interactive learning' with a major part of the training time alloted for practicals, field experience and role play. Several important documents like *National Health Policy* (1982), *Organization of Mental Health Services in Developing Countries* (WHO - 1975) and different mental health manuals are reviewed by the participants. Basic principles of teaching and training health personnel are got across through role plays. Towards the later part of the programme participants are assisted to plan for a feasible programme aimed at extension of mental health services. The outcome of the training is better understanding by the trainees of the functioning of the health, welfare and educational infrastructures and the rural community along with acquiring of skills to plan training programmes, support non-specialists and evaluate the extension programmes.

To-date 63 mental health professionals from different parts of the country (42 psychiatrists, 11 clinical psychologists, 5 psychiatric social workers, 2 psychiatric nurses and 3 MPW trainers) in addition to 28 from other developing countries namely Male, Indonesia, Nepal, Bangla Desh, Srilanka and PDR Yemen have participated in these programmes. Many of the Indian participants have initiated training programmes for PHC personnel and other activities aimed at extension of services. Notable amongst these are programmes started at places like Pondicherry (UT), Amritsar (Punjab), Hamirpur (HP), Hyderabad and Thirupathi (AP), Nagpur, Pune, Ratnagiri, Thane, (Maharashtra), Lucknow (UP), Jaipur (Rajasthan), Karnal, Bhiwani and Ambala (Haryana) Trivandrum (Kerala) and Delhi (UT). Many of these programmes were carried out with active support and resource persons from the Unit.

WORKSHOP ON IMPLEMENTATION OF NMHP FOR STATE LEVEL PLANNERS

An important initial outcome of the 'Training of Trainers' programme was the two days workshop for health planners from their respective states (Secretaries of Health, Directors of Health/ Medical Education and Senior Psychiatrists) on implementation of NMHP. In most of the states mental health continued to be a neglected area and had never been identified as part of basic health care. Active involvement and support of the health planners are essential for providing mental health care through existing health infrastructure. Hence workshops were organized for state level health planners with the objectives of: i) reviewing mental health services in participating states, ii) reviewing the development of community mental health care approaches in the country and the development of NMHP and iii) developing mechanisms to implement NMHP in their states.

The first workshop (February 13-14, 1984) included planners from Andhra Pradesh, Madhya Pradesh, Rajasthan and Uttar Pradesh. The participants of the second workshop were from Haryana, Himachal Pradesh, Maharashtra, and Pondicherry (U.T.) (August 16-17, 1985). The third workshop involved the state planners of Kerala, Jammu and Kashmir, Gujarat, Punjab, Tamil Nadu and Goa (U.T.) (February 13-14, 1986).

The first day of each workshop was devoted to the review of current mental health activities and constraints in functioning. Next the National Mental Health Programme was discussed and different approaches to Community Mental Health were reviewed. Following this, on the second day, the state level teams met with resource personnel to develop specific plans to implement the National Mental Health Programme in the respective states. (Narayana Reddy *et al* 1986).

Similarly, a five day workshop on implementation of NMHP was organized in April 1986 for state health education officers and senior mass media personnel attached to the health department. Haryana, Punjab, Maharashtra, Kerala, Andhra Pradesh, Karnataka and Goa were represented in this workshop.

WORKSHOP ON NATIONAL MENTAL HEALTH PROGRAMME

First workshop of NMHP for State level health planners - February 1984 - A session in progress.

Valedictory function of the second workshop of NMHP for State level health planners - August 1985. Smt. Meera Seth, Health Secretary, Haryana, Smt. Mohsina Kidwai, Union Minister for Health and Family Welfare, Dr. H.L.Thimme Gowda, Minister of Health and Family Welfare, Govt. of Karnataka and Dr. Ramalingaswamy, DG, ICMR on the dias.

WORKSHOP ON NMHP FOR MENTAL HEALTH PROFESSIONALS

The different States and Union Territories of the country have striking differences in the development of health services in general and mental health services in particular. Hence, there is a need to consider modifications in the NMHP to suit the specific conditions in each of the states and union territories and develop state level plans for the implementation of the programme. To achieve this, state level workshops for Psychiatrists were organized with the following aims:-

i) Review the existing mental health care facilities in the state and the constraints in functioning,

ii) Review the background to community mental health approach and development of NMHP, and

iii) Develop recommendations to integrate mental health with primary health care in the state.

Such state level workshops were held in Andhra Pradesh (October 4, 1985), Karnataka (November 22, 1985), Himachal Pradesh (November 30, 1985), Maharashtra (January 11, 1986), Punjab (February 1, 1986), Rajasthan (April 9, 1986) Haryana (April 10, 1986), Tamil Nadu (April 21, 1986), Kerala (May 3, 1986) and Gujarat (June 13, 1986).

Workshops for Psychiatric Social Workers and Clinical psychologists on implementation of NMHP were held in March and July 1986 (Narayana Reddy *et al* 1986).

ICMR AND THE COMMUNITY MENTAL HEALTH UNIT

The need for extending mental health services into the community, resulted in the Indian Council of Medical Research funding projects in this area. One of the major collaborative studies in the field of mental health funded by ICMR has been the 'Severe Mental Morbidity Survey' (1976–84). Based on the principles of decentralization and integration of mental health with primary health care, this project was carried out in 4 centres - Bangalore, Baroda, Patiala and Calcutta. The Bangalore centre was the co-ordinating centre. PHCs, population and personnel to be trained were identified at all the 4 centres. After a brief training (with pre and post training assessments and using the manuals developed at NIMHANS) all the health workers and doctors at the PHC carried out identification and management of persons with mental disorders and epilepsy for an year. After an year, their work was assessed and a survey was carried out in study areas to determine the actual prevalence of psychiatric disorders.

This study showed that primary health centre personnel can be successfully trained and utilised for basic mental health care in rural areas. It highlighted the need for supports of various nature and continuous supervision and monitoring to enhance the efficiency of the health personnel (Severe Mental Morbidity Project - Final Report ICMR 1986).

While, the community psychiatry unit was going ahead with its various programmes on delivery of mental health services, the need for stimulating community mental health

activities at various other centres and departments of psychiatry, was realized by ICMR Scientific Advisory Body on mental health in 1980. An outcome of this realization was the offer of 8 fellowships 'for mental health personnel in extension of mental health services in the community' for a period of 6 weeks. In 1981 seven mental health personnel – all psychiatrists hailing from various places in the country were provided training at the community mental health unit for 3 weeks in 'extension of mental health services in the community' as part of their 6 weeks fellowship, at Bangalore, Chandigarh and Delhi. (Refer *Training of Trainers* above). These efforts and the support from ICMR have helped in sensitizing more mental health professionals to the needs in the area of delivery of mental health services.

ICMR CENTRE FOR ADVANCED RESEARCH ON COMMUNITY MENTAL HEALTH

Another major recommendation of the Scientific Advisory Body of the Council (6–7, October 1980) was to fund the setting up of a centre for advanced research on community mental health with the objective of encouraging longitudinal research in this field. The community mental health unit at NIMHANS was chosen for setting up of the above advanced centre. This choice was based on the long-term commitment of the institute in this area of work starting from 1975–76. The centre was inaugurated in September 1984 at

Dr. V. Ramalingaswamy, DG, ICMR, releasing the Document of the ICMR Advanced Centre in the presence of Dr. B. Shankaranand, Union Minister of Health and Family Welfare and Dr. H.L. Thimme Gowda, Minister of Health and Family Welfare, Govt. of Karnataka, September 1984.

the rural mental health centre, Sakalawara by Sri. B. Shankaranand - the then Union Minister of Health and Family Welfare. The global aims of the centre were as follows:

1. To develope and evaluate suitable models for provision of basic mental health care, in consonance with the health policies and plans of the country.
2. To undertake epidemiological, phenomanological, and intervention research to assist in the development of models of mental health care.
3. To be a centre of training for mental health personnel in the country and others with interest in the extension of mental health services in the community.
4. To initiate development and standardisation of psychiatric epidemiological tools that are socio-culturally relevant to the Indian situation.
5. To act as a clearing-house for dissemination of information regarding innovations in mental health care and related issues to professionals, planners, administrators and the general public.

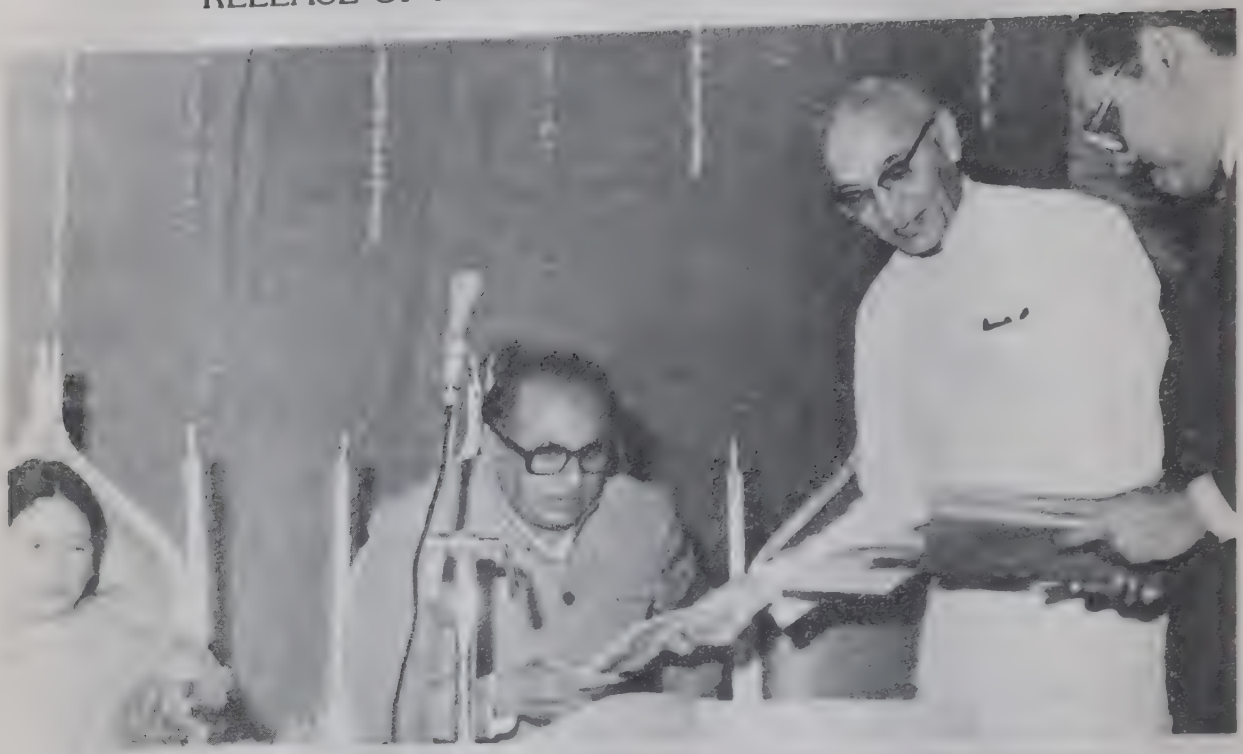
During the past two years, various activities have been initiated by the centre to fulfill the above aims. The project "Mental Health in Primary Health Care" was initiated at Solur PHC in Bangalore Rural District. Following the completion of the baseline studies and training of personnel, the intervention by the trained PHC Personnel was started. Now the first years intervention data relating to the work of Community Health guides, MPWs and Medical Officers are available. This shows that the PHC Workers are able to identify mentally ill persons and refer them to the health centre and medical officers can organise weekly mental health clinics. The simple recording and reporting system developed, has been found to be practical for use in the field setting. A number of evaluative tools have been developed. These have been found to be of value by other centres taking up similar work in India and abroad.

A workshop on 'Community Mental Health in India' was organised from Oct. 11 to 13, 1985. About 50 professionals participated and 20 working papers were presented. The workshop reviewed the work of 1975–85 period and recommended future areas of work. Specific recommendations have been made on primary health care research, advances in mental health training and know-how and the aspects relating to community participation. (*Report of Workshop on Community Mental Health in India* - ICMR/ACMH/No. 4 1985).

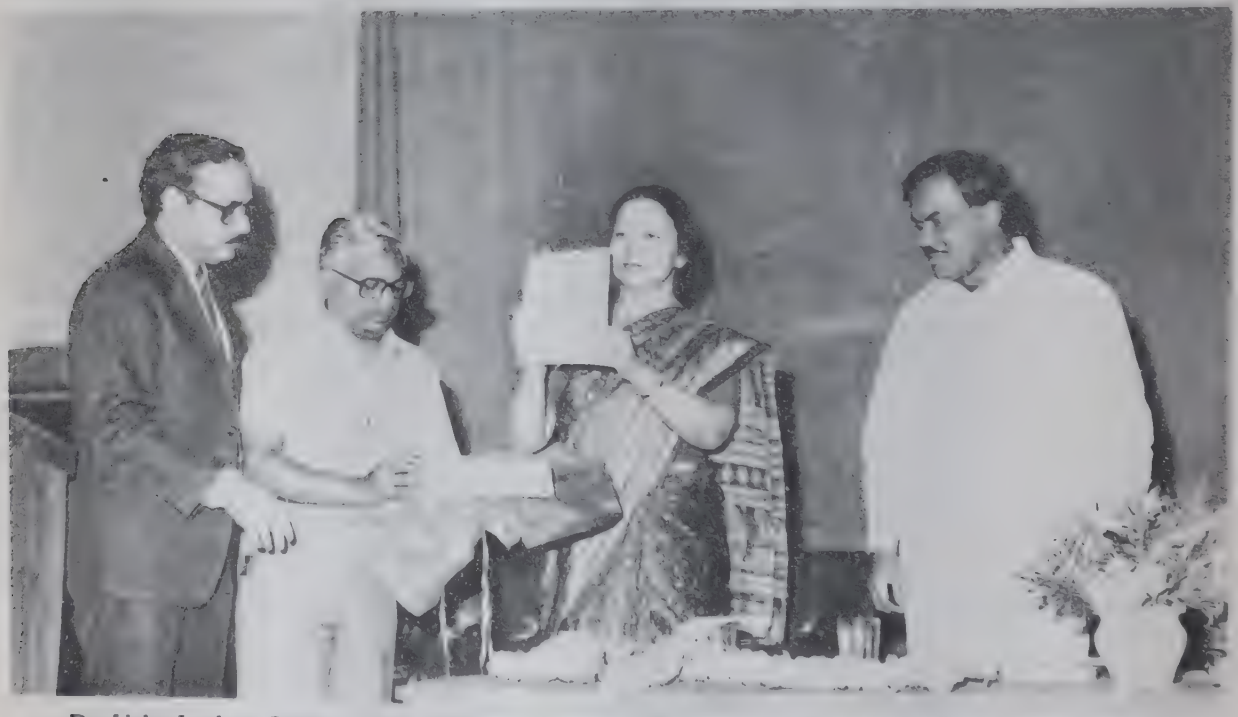
The staff of the centre visited the Bhopal Disaster population and assessed their mental health needs in April - May 1985. Following this two training programmes of one week each were organised for the medical officers working with the disaster population. A special mannual developed for this purpose was used for the training (Srinivasa Murthy *et al* 1985, Srinivasa Murthy and Issac 1985). It is noteworthy that this is the first major effort by mental health professionals to be involved in disaster care.

Three training programmes for mental health professionals of 4 weeks duration each were organised in September 1985, November 1985 and December 1986. 4, 6 and 4 persons were participated in the training programmes (Refer *'Training of Trainers'* above).

RELEASE OF MANUALS OF MENTAL HEALTH



Dr. Ramalingaswamy, Director General, ICMR, releases the Manual of Mental Health of Multipurpose workers' by giving copies to Dr. H.L. Thimme Gowda and Smt. Mohsina Kidwai.



Dr. Usha Luthra, Senior Deputy Director General, ICMR releases the Manual of Mental Health Care for Medical Officers as Mr. P.G.R. Scindia, Minister of State for Health, Govt. of Karnataka looks on.

Workshop on 'Community Mental Health in India' October 1985 - A session in progress.

One of the neglected areas in the field of delivery of mental health care services has been the preparation of mental health education materials. The centre has developed, field tested and produced avisual material 'features of mental disorders' for health education. Preparation of appropriate visual materials for the 'manuals of mental health' has been planned.

The centre has already published three issues of its news letter **'Community Mental Health News'**. They are being widely circulated amongst professionals, planners and administrators. The centre also has taken up dissemination of information regarding various innovative mental health care programmes.

Initial work on a major epidemiological project termed 'Longitudinal study of mental health problems in a PHC area' is presently being carried out. A Workshop on 'Issues in Psychiatric Epidemiological Research' has been planned for February 1987.

MENTAL HEALTH CARE IN URBAN AREAS

Most of the existing psychiatric services (hospital beds, trained personnel, etc.) are situated in urban areas. Studies have shown that even these services provide care, only for a small percentage of the urban population in need of help. There is also the additional problem of under utilisation of the existing services. It is well known that a large number of people in the cities and big towns seek help from the private general practitioners. Bangalore city has more than 2,500 general practitioners. It is well documented that a good percentage of the patients who see a general practitioner (GP) suffer from various types of minor psychiatric disturbances, not only in the West, but also in our country. It is widely

accepted that the current psychiatric training of medical undergraduates is not sufficient and most of the GPs in the country have limited knowledge of Psychiatry to recognise and manage common psychiatric problems in their day to day practice. With this need in view and with an aim to involve general practitioners in the provision of mental health services, an urban mental health centre — "The mental health clinic" — was started at the K. C. General Hospital at Malleswaram — 15 kms from NIMHANS, in a different part of the city.

The K. C. General Hospital is a 350 bedded non-teaching general hospital in Bangalore. The mental health clinic was started there by the community psychiatry unit in 1977, with the aim of acting as a consultatory agency and to establish active liason with the general practitioners in the surrounding areas. The plan was to provide mental health services mainly through the local general practitioners (Shamsunder *et al* 1978). For this purpose, the general practitioners had to be sensitized to the mental health problems in the community and amongst their clientele. They also needed training in basic aspects of mental health care.

Most of the GPs around the mental health clinic were contacted both personally and by post. They were told about the mental health clinic and the consultatory services offered at the clinic. They were encouraged to refer their patients to the clinic for consultation and were invited to personally visit the clinic for discussion regarding their psychiatric patients. Whenever a GP referred a patient he was sent a report describing the clinical features and management of the case. This was supplemented by a visit by psychiatric social worker attached to the unit as and when required. The patient was referred back to the GP as soon as the psychiatric consultant and the GP were confident that the latter could take care of the problem. The psychiatric social worker made regular visits to the GPs who referred cases and who were treating cases referred back to them from the mental health clinic, enquiring about the follow-up and offering additional help when required.

Later on, monthly seminars were started for the GPs on mental health topics. This was converted to a regular training programme in mental health and offered to the GPs free of charge. The actual training consisted of 1–2 hours sessions of discussion of case material presented by participant GPs (Shamsunder *et al* 1980).

Based on this experience, a structured training programme was designed conducted and evaluated. It consisted of weekly three hour sessions for 3 months. This was offered to general practitioners who responded to newspaper announcement of the course and were willing to pay Rs. 150/- for the course (Shamsunder *et al* 1982). Lectures, and discussions with aduio-visual aids, discussion of trainee doctors case material and practical clinical training at the out patient setting were used for the training.

As this programme of involving the general practitioners in mental health care progressed, it was realised that such courses lasting for several weeks can be attended only by the GPs working in the city, where the course is offered. Hence, for the sake of general practitioners in semi-urban areas and smaller towns like taluk headquarters the unit designed a programme of short duration mental health training coupled with a mental health camp

(Kapur *et al* 1982). Here, the training was offered over a period of 2-3 days, in about 6-8 sessions of two hourse each. This was folowed by a mental health camp on the next day, where in the patient primarily referred by the local doctors were jointly examined and treatment advised. Usually about 150 patients attend such camps. The training was completed with the clinical demonstration of camp patients and the doctors were guided in the further follow-up of the patients. Such programmes have been held in 2 taluk headquarters and one district headquarter town, Kollegal, Ramanagaram and Mandy respectively.

The GPs were assessed for their knowledge regarding basic mental health care before the training as well as after the completion of the training. In the various programmes described, there has been a significant change in the post training assessment scores. Thus depending uon the feasibility and the background and interest of the group of GPs, training programmes of long duration, medium duration or short duration have been provided.

Many of the GPs who have attended these courses are active members of the Indian Medical Association and some of the programmes particularly in the semi-urban areas were organized by the local branches of the IMA in conjunction with voluntary agencies like the Rotary Club and Lion's Club.

Realizing the significance of training the general practitioner as an important approach to extend mental health services into the community, the ICMR, New Delhi supported a project on training of GPs. Investigators from Hyderabad, Vellore and Bangalore (with Bangalore as the co-ordinating centre) recently completed a collaborative research project of training GPs according to the medium duration training model developed initially at Bangalore.

HOME CARE FOR SCHIZOPHRENICS

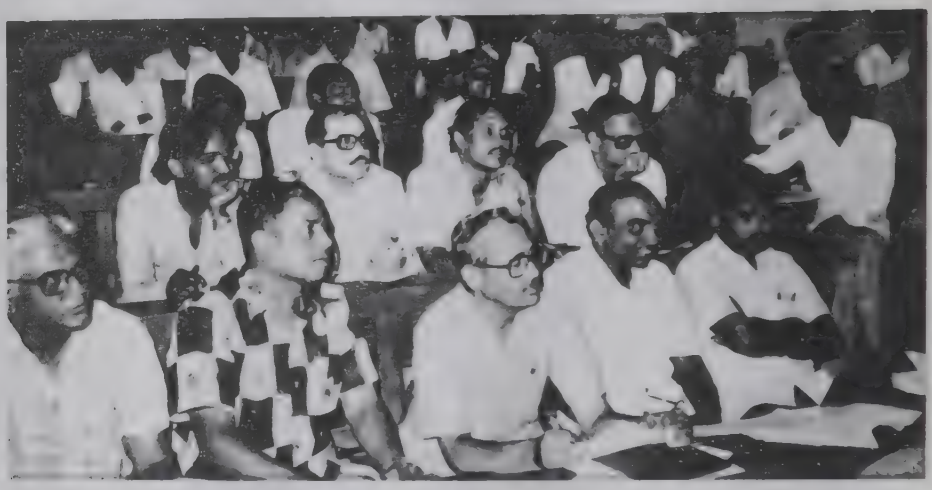
In the urban setting a group of first onset schizophrenics managed at home after the initial hospital assessment by a visiting nurse was compared with a matched control group who underwent regular hospital treatment. They were followed up for a period of 6 months and assessed at 8 different points of time on clinical severity, social functioning and burden on the family. The home group consistently did better on all the three parameters, after the first month. The differences were more marked on the parameter of burden on the family and social functioning (Pai 1980, Pai and Kapur 1981, 1982.) As a result of these studies, the rural centre continues to offer domiciliary care. A new 'home care service' facility where patients, after the initial assessment in hospital, are managed by their families at home assisted by a visiting nurse has been started in two of the clinical units at NIMHANS.

MENTAL HEALTH CARE IN SCHOOLS

Another area in which the unit focussed its initial attention was the problem of mental health in schools. While there was an overall neglect of mental health in general, child mental health services are least developed. Trained child psychiatrists or other mental health professionals specially trained to work with children, child guidance clinics and other

DISTRICT MENTAL HEALTH PROGRAMME, BELLARY

Dr. D.H. Deshpande, Div. Jt. Director Health and Family Welfare Services, Gulbarga div. inaugurating training programme for PHC personnel at Bellary 1984.



P.H.C. Medical Officers of Bellary District during a training session - 1984.

Multipurpose health workers of Bellary District undergoing training in mental health care - 1984.

specialized services for children like counselling services in schools, are limited. The Unit's attempt was to create referral and counselling resources in the community, outside the hospital/clinic set up by training school teachers. More specifically the aims were to (a) sensitize the school teachers to the presence of emotional problems amongst school children (b) improve their attitudes to the emotionally disturbed, (c) select and train counsellors, from amongst the school teachers and (d) monitor and evaluate the school counsellors training programme.

As a first step, in the beginning of 1977 an orientation course was given to 28 teachers from schools of different descriptions. Their attitude and knowledge were tested before and after the orientation course. Both knoweldge and attitude showed change following the orientation course.

Following this, from amongst the 28 teachers, nine were considered to be potentially good counsellors and were trained for twelve, two-hour sessions. Each session was built around a case presented by the teacher from his or her own school. The experience gained from this exercise helped the unit to plan and organize similar orientation and counselling programmes for school teachers in other schools.

Similar programmes were conducted and evaluated in two other schools in Bangalore. A result of these, two programmes has been the development of a general training programme on child mental health for all categories of school teachers. The focus is to sensitise them to emotional problems in children. A more intensive programme for interested and suitable teachers on counselling has also been developed. (Kapur & Cariapa 1978, 1979, 1979a, Kapur *et al* 1980). A manual providing guidelines for school teachers is available.

During the past two years, the Unit has focussed its efforts at schools in the rural areas. Pilot exercises have been completed at a rural High School in Jigani, about 6 kms. away from the Sakalawara centre. Here, the effort is to interact with the school students (13–16 years) on a regular basis and test the practicability of developing 'mental health know-how' for improving the overall performance of students (Parthsarathy *et al* 1985). This work has expanded to more schools and in presently entering the evaluation phase.

ANGANWADI WORKERS AND CHILD MENTAL HEALTH CARE

Paucity of trained personnel calls for decentralization of mental health care through peripheral health workers. The Anganwadi workers with their training in child development can successfully learn to identify and manage children with mental handicap and other mental health problems provided she has adequate supervision.

The unit started training programmes for Anganwadi workers in 1984. The trainees who underwent training were those deputed for 3 months training in the ICDS. The objectives were to sensitize Anganwadi workers on aspects of psychological, social and motor development of a normal child and to equip them with enough knowledge to identify, refer

and follow up children with mental handicaps. The modus operandi used were lectures, group discussion, role plays, case demonstrations and field visits. Audio visual aids and printed materials were used to enhance the training. 6 batches, since 1984 have been trained. The number in each varied from 36 to 45 — they were all women. Simple methods to evaluate the knowledge on mental health prior to and after the training were designed.

The unit is presently involved in the follow-up of trained workers to evaluate their efficacy and difficulties in the practical situation. To enhance training efforts, there is need to prepare manuals of instructions, good quality audio visual teaching aids and also child mental health needs to be included in the syllabus and the training of ICDS functionaries.

CURRENT ACTIVITIES OF THE COMMUNITY MENTAL HEALTH UNIT

The Unit's current activities could be considered under the three areas of service, training and reserach.

SERVICES

1. Outpatient services at Sakalawara

Primary health care and neuropsychiatric out-patient services are provided on all days of the week at the Sakalawara Centre. In addition there are facilities for emergency services. Two general duty medical officers who resides at the centre, assisted by residential staff nurses offer these services. There is limited in-patient facilities not only for psychiatric but also for medical emergencies. The primary care facilities are made use of by villagers around the centre for whom the nearest governmental primary care services are more than 5 kms away.

2. Mental Health clinics at PHC/PHU

With the active collaboration of the primary health care staff of Anekal PHC, the Unit runs regular weekly mental health clinics at Anekal PHC on Thursdays and Saturdays, Jigani PHU on Mondays and Marsur PHU on Thursdays. Large number of neuropsychiatric patients are regularly followed up at these clinics.

3. Support to PHC and ICDS Personnel

The unit supports and monitors the mental health care activities of PHC personnel at Solur PHC and in Bellary District. It also supports the work of trained ICDS personnel in Anekal Taluk.

TRAINING

The mental health centre at Sakalawara is essentially a training centre and it offers various types of training programmes of varying duration and intensity to different categories of personal as follows:

1. Mental Health Professionals undergoing training at NIMHANS

The steady growth and increase in range and number of activities of the unit during the past

few years has resulted in the evolution of a crystallized training programme with specific objectives for mental health professional trainees of NIMHANS. It started with postings in community psychiatry, initially only for the DPM & MD trainees. M.Phil in psychiatric social work, M.Phil in clinical psychology and Diploma in psychiatric nursing trainees were posted on a regular basis later on. Currently, there is a one month training in community mental health offered to DPM, MD, M.Phil in Psychiatric Social Work and Clinical Psychology trainees. The effort is to make this an experience based training giving the students a critical appraisal of the various issues and problems involved in 'Community mental health' in the present Indian setting. For the DPNs there is a 15 days residential training.

2. Mental health professionals from other institutions

Trainees who are posted to NIMHANS from other institutions, spend part of their period of training, with the community mental health unit.

3. WHO/ICMR Funded "Training of Trainers"

4 weeks "Training of Trainers" programme for mental health professionals from different parts of the country and other developing countries are carried out several times a year.

4. Trainees in allied disciplines, from other Institutions

Master students in social work from various schools of social work, general nursing students from different colleges of nursing etc. get orientation in community mental health at the Sakalawara centre during their placement at NIMHANS. They are trained for different periods at the Sakalawara centre.

First batch of PHC trainees with faculty (April 1982).

5. Primary Health care personnel

Medical officers and multipurpose workers from various PHCs in Karnataka are deputed by the State Government for basic mental health training to the Sakalawara centre. Presently, the health workers are deputed for a week and the medical officers, for two weeks. These are regular monthly training programmes.

6. Anganwadi workers

The Centre offers a 3 days training programme for Anganwadi workers (personnel selected for appointment by the integrated child development services (ICDS) programme at Anganwadi). These workers are sent to the Sakalawara centre for training in Mental Retardation, by the Principal of the Anganwadi Training Centre at Anekal.

RESERACH

The unit has a strong commitment to reserach, mainly in the area of 'mental health service delivery'. The broad areas of interest centre around improving the quality of training programmes for PHC personnel. This would mean alternative methodology of training, development of suitable aids (including audio visual) for training, revisions of manuals, more sensitive methods for evaluation of both knowledge gained as well as effectiveness in the community, development and testing of simple reporting and recording schedules etc. The district, mental health programme at Bellary has incorporated many of the new changes brought about by past experience of the Unit and it offers wide scope for continued reserach into various aspects of mental health care through primary health care personel. In addition work is progressing in the following areas:-

i) Work on identifying the training needs of pre-school workers (Anganwadi) for child mental health care has resulted in draft manuals and an intervention phase of work is planned.

ii) Programme of mental health promotion in school children (aged 13-16 years) in rural schools is entering an evaluation phase.

iii) An approach to involve the community sources other than the above agency personnel (e.g., families, villages leaders) is being finalised for systematic intervention and evaluation.

iv) Develop simple and effective approaches to the management of minor psychiatric problems presenting to the health personnel working in primary health care settings is to be initiated.□

COMMUNITY MENTAL HEALTH UNIT

DISSERTATIONS

M.D.(Psychiatry)

Isaac M.K. (1978): **Cost/Effectiveness analysis of three different methods of psychiatric case finding in the general population.**

Chandrashekhar, C.R. (1979): **Mental illness in research studies — Relationships with attitudes and life stresses.**

Gautham, S.K.S. (1979): **Evaluation of techniques for psychiatric training of General Practitioners.**

Bhide, A.V. (1982): **Prevalence of psychiatric morbidity in a closed community in South India.**

John, C.J. (1982): **phenomenology of Neuroses.**

Kurup Shalini (1982): **An epidemiological study of psychiatric morbidity in rural children.**

Subramanya, B (1983) **An epidemiological study of mental retardation in rural children.**

Krishnamurthy, C.N.(1985) **Prevalence of psychiatric morbidity among the rural aged.**

Manjula, B.N.(1986): **Psychiatric morbidity in music students.**

Rajbhandari, K.C.(1986): **Assessment of short term psychiatric training for primary health centre — Medical officers.**

Ashok, D.A. (on going) **Evaluation of PHC personnel: one year after mental health training.**

M.Phil. (Clinical Psychology)

Rao Kiran (1980): **A study of psychological disturbances in a medical outpatient.**

M.Phil(Psychiatric Social Work)

Parinitha J (1980): **A study on the impact of orientation programme in mental health given to the village leaders.**

Ph.D (Mental Health)

Pai S (1980): **A comparative study of first admission Schizophrenics treated at home and in the hospital.**□

PRESENT STAFF OF COMMUNITY MENTAL HEALTH UNIT AND ICMR CENTRE

Medical

1.	Dr. R. Srinivasa Murthy Prof. of Psychiatry	1982
2.	Dr. Mohan K. Isaac Assoc. Professor of Psychiatry	1976
3.	Dr. C.R. Chandrashekar Asst. Prof. of Psychiatry	1979
4.	Dr. Shekar Seshadri Lecturer in Psychiatry	1986
5.	Dr. H. Mahadevappa General Duty Medical Officer (on study leave)	1980
6.	Dr. Sunder Moily GDMO (Psychiatry)	1985
7.	Dr. K.V. Kishore Kumar GDMO (Psychiatry)	1985
8.	Dr. Mamatha Shetty GDMO — Research Officer	1986
9.	Dr. Jayaprakash GDMO — Research Officer	1985
10.	Dr. Gangadhar GDMO	1986

Non-Medical

11.	Dr. R. Parthasarathy Lecturer in Psychiatric Social Work	1978
12.	Mr. Chandrashekar Rao Lecturer in Psychiatry Social Work	1983
13.	Dr. K. Sekar Lecturer in Psychiatric Social Work	1984
14.	Mr. Mahendra Prasad Sharma Lecturer in Clinical Psychology	1986
15.	Mrs. Bijette P. Varghese Clinical Psychologist	1985

16. Mr. Udaya Kumar
Psychiatric Social Worker — 1985

17. Ms. J. Parinitha
Research Officer (NM) — 1986

18. Mr. Joseph Panackal
Research Officer (NM) — 1986

19. Mr. Soman Ponnempalath
Assistant Editor — 1986

20. Mr. G. Govindaraj
Artist — 1985

Nursing

21. Mr. Nagarajaiah
Tutor in Psychiatric Nursing — 1976

22. Ms. Premalatha Chinnaiah — 1982

23. Ms. Puttamma — 1984

24. Mr. Hiremath — 1985

25. Mr. Bheemaiah — 1986

26. Mr. Subramanya — 1980

PAST STAFF

Medical

1. Prof. R.L. Kapur
Professor of Community Psychiatry — 1975 - 1982

2. Dr. C. Shamsunder
Associate Professor of Psychiatry — 1976 - 1982

3. Dr. S. Kalyanasundaram
Associate Professor of Psychiatry — 1976 - 1981

Non-Medical

4. Dr. (Mrs) Malavika Kapur
Asst. Prof. of Cl. Psychology — 1976 - 1982

5. Ms. Nomitha Varma
(Lecturer in Cl. Psychology — 1985 - 1986

6. Ms. Kshama
Lecturer in Psy. Social Work — 1976 - 1979

7. Dr. G. Nardev
Asst. Prof. of Psychiatry Social Work — 1976 - 1978

8.	Dr. (Mrs) Shaila V. Pai Asst. Prof. of Psychiatry Social Work	1976 - 1983
9.	Ms. Shaline Shetty Psychiatric Social Worker	1981 - 1982
10.	Mr. Rajaram R. Psychiatric Social Worker	1981 - 1983
11.	Mr. T.S. Chandrashekar Psychiatric Social Worker	1982 - 1983
12.	Ms. Nalini Cl. Psychologist	1985 - 1985
13.	Ms. Anni Amma Mathew Cl. Psychologist	1986 - 1986
14.	Mr. C. Ramesh Research Officer (Statistics)	1984 - 1986

Nursing

1.	Ms. T.P. Prema	1978 - 1983
2.	Ms. G.K. Nagarthna	1978 - 1979
3.	Ms. Dorothy John	1979 - 1980
4.	Ms. Rachel George	1980 - 1983
5.	Ms. A.G. Pereira	1981 - 1983
6.	Ms. V.P. Mariam	1981 - 1982
7.	Ms. S.S. Prabhu	1983 - 1985
8.	Ms. S.Sukanya	1983 - 1984
9.	Ms. Rani Xavier	1983 - 1984

COMMUNITY MENTAL HEALTH UNIT & ICMR CENTRE FOR ADVANCED RESEARCH IN COMMUNITY MENTAL HEALTH

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12. Kalyanasundaram, S., Isaac M.K. and Kapur R.L. (1980) *Introducing Elements of Psychiatry into Primary Health Centre in South India*. **Indian Journal of Psychological Medicine, 3**: 91–94.
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45. *Project Protocol: Mental Health in Primary Health Care.*

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GOVERNING BODY OF NIMHANS

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Union Minister for
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Government of India
New Delhi

Vice-Chairman

Mr. H.T. Krishnappa
Minister for Health
Government of Karnataka
Vidhana Soudha
Bangalore

Members

Secretary
Ministry of Health & Family Welfare
Government of India
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Mr. S. S. Dhanoa

Director General
Indian Council of Medical Research
New Delhi
Dr. A. S. Paintal

Vice-Chancellor
Bangalore University, Bangalore
Dr. D. Shankar Narayan

Director General of Health Services
Government of India
New Delhi
Dr. Vishwakarma

Joint Secretary & Financial Advisor
Ministry of Health & Family Welfare
Government of India
New Delhi
Mr. R. M. Bhargava

Commissioner and Secretary to
Government of Karnataka
Finance Department
Vidhana Soudha
Bangalore
Mr. M. Sankaranarayanan

Commissioner and Secretary to
Government of Karnataka
Health & Family Welfare Services
Vidhana Soudha
Bangalore
Sri. A. Ravindra

Director of Medical Education
Government of Karnataka
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Dr. S. T. Nagalinga Shetty

Nominee of the Chairman
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Professor and Head of the
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All India Institute of
Medical Sciences
New Delhi

Nominee of the Vice-Chairman
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Director
Sri Chitra Tirunal Institute of
Medical Sciences & Technology
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Members of the faculty of NIMHANS

Dr. (Mrs.) Sarala Das
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Dr. Viney Kumar Jain
Professor & Head
Department of Bio-physics

Dr. P. S. Gopinath
Associate Professor of Psychiatry
Department of Psychiatry

Dr. I. A. Sheriff
Professor & Head
Department of Psychiatric Social Work

Member/Secretary

Dr. G. N. Narayana Reddy
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